EXPEDITED SERVICE DELIVERY AGREEMENT

I, _____ hereby declare that all of the information I have provided on the HCBS/FE Expedited Service Delivery Financial Screening Worksheet is true and correct.

I understand that the HCBS/FE Expedited Service Delivery Financial Screening Worksheet is **NOT** an application for Medicaid benefits. I further understand that the Expedited Service Delivery services ("ESD"), which I may qualify to receive, are only **TEMPORARY** and will not include Oral Health or Assistive Technology Services.

I understand that to receive the temporary ESD services, I must apply to SRS for Medicaid financial determination within 10 days following the date of this agreement and I will call the Case Manager upon my turning in the application to SRS. I further understand if I fail to apply to SRS for Medicaid, the temporary ESD services shall end.

I understand that while I have the right to appeal SRS's Medicaid eligibility determination, the temporary ESD services shall **NOT** continue during such appeal, and I hereby knowingly and voluntarily waive any applicable rights regarding the continuation of such temporary services.

_____ _____
(Customer initials) (Date)

I understand that my temporary ESD services shall start with the date contained in the Notice of Action sent to me by my Case Manager, and may continue for a maximum of 45 calendar days following the date such services were authorized to begin.

I understand that upon my notification in writing by SRS that I am ineligible for Medicaid, the temporary ESD services shall end.

I have read the above and foregoing agreement (or have had the same read to me); I understand its contents and agree to comply.

_____ _____
(Customer signature or mark) (Date)